TIP 29: Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities

Substance Use Disorder Treatment For People With Physical and Cognitive Disabilities
Treatment Improvement Protocol (TIP) Series 29
Dennis Moore, Ed.D., Consensus Panel Chair
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. (SMA) 98-3249
Printed 1998

Executive Summary and Recommendations

Nearly one-sixth of all Americans have a disability that limits their activity; countless others have disabilities (mostly cognitive in nature) that go unrecognized and undiagnosed. The Americans With Disabilities Act (ADA) was signed into law in 1990 to ensure equal access to all community services and facilities, including substance use disorder treatment facilities both public and private, for all people regardless of any disability they might have. People who are blind, deaf, paraplegic, and who have arthritis, heart disease, human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), mental illness, and substance use disorders are among those covered under this legislation.

People with physical and cognitive disabilities are more likely to have a substance use disorder and less likely to get effective treatment for it than those without such a coexisting disability. There are already many people in treatment who have a coexisting cognitive or physical disability. But, as many still go untreated, the number of people with coexisting disabilities entering treatment can only be expected to rise. Treatment programs have a legal and ethical responsibility to make treatment for these clients as effective as possible.

The ADA states that both public and private facilities be equally accessible for all. The law requires the installation of ramps, elevators, proper lighting, and usable doorknobs, and the removal of other physical obstacles, but accessibility means more. Barriers to communications must be removed; discriminatory policies, practices, and procedures eliminated; and attitudes changed in order to not hold a person's disability against him. Accommodating people with coexisting disabilities in treatment for substance use disorders entails such things as adjusting counseling schedules, providing sign language interpreters, suspending "no-medication" rules, and often, overcoming people's fears and ignorance. This TIP presents simple and straightforward guidelines on how to overcome barriers and provide effective treatment to people with coexisting disabilities.

The topic of substance use disorder treatment for people with coexisting disabilities is a broad one. In creating this Treatment Improvement Protocol (TIP), the Consensus Panel focused its

attention on the needs of adults in treatment who had a coexisting physical or cognitive disability (including those disabilities also classified as "sensory" in nature). While people who have an affective disability (i.e., mental illness) are mentioned in the TIP, the reader is referred to TIP 9, A*ssessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994), for more detailed information concerning the assessment and treatment of these clients.

In order to avoid awkward construction and sexism, this TIP alternates between "he" and "she" for generic examples. Since substance use disorders are considered a disability under the ADA, when people in substance use disorder treatment are referred to in the TIP as having disabilities it is understood that they have "coexisting" disabilities.

The Consensus Panel for this TIP drew upon its considerable experience in both the disability services and substance use disorder treatment fields. Panel members included providers as well as consumers of these services. Because of a lack of substantial research on the particular needs of people with coexisting disabilities in treatment for substance use disorders, the Panel often relied on clinical experience to develop the recommendations provided here. In the summary of recommendations listed below, recommendations that are supported by research literature or legislation (i.e., the ADA) are followed by a (1); clinically based recommendations are marked (2). Citations supporting the former are given in Chapters 1 through 5.

Summary of Recommendations

This TIP is organized into five chapters, the first of which presents an overview of the issues involved in providing substance use disorder treatment for people with coexisting disabilities. It provides important definitions, relevant research findings, and a discussion of barriers to treatment for people with coexisting disabilities. The second chapter presents methods of screening for disabilities and ways in which substance use disorder treatment may need to be modified for people with coexisting disabilities. Chapter 3 discusses treatment planning and counseling, and gives specific recommendations concerning how treatment can be modified to be most effective for people with specific disabilities. Information on forming and maintaining linkages with other service providers is provided in Chapter 4. The final chapter is aimed at program administrators and discusses issues such as staff training, funding mechanisms, marketing, and demonstrating an organizational commitment to working with people who have coexisting disabilities. The recommendations that follow are, however, grouped thematically and not according to the chapters in which they are found.

Making Accommodations To a Program

- Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for persons with disabilities: attitudinal barriers; discriminatory policies, practices, and procedures; communications barriers; and architectural barriers. (1)
- *Accommodation* does not mean giving special preferences--it does mean reducing barriers to equal participation in the program. (1)

- When barriers cannot readily be removed, a program must find alternative methods to make its services available. (1)
- Staff training is key to overcoming most barriers to treatment, especially attitudinal barriers. Such training should be ongoing and comprehensive. All program staff should be trained in understanding functional limitations, the wide variety of conditions that lead to them, and the barriers that treatment-as-usual may present for persons with specific disabilities. Training should strongly encourage and reward staff members who find creative ways to adapt treatment procedures for people with coexisting disabilities. Because they are the initial points of contact, receptionists and other support staff should receive special training to prepare them to respond knowledgeably and sensitively to people with coexisting disabilities. (2)
- If there is any doubt on the part of the provider regarding the legitimacy of a person's request for accommodation, a disability expert should be consulted to evaluate the request. (2)
- In general, it is beneficial and feasible to integrate people with coexisting disabilities into already existing community-based services used by nondisabled individuals recovering from substance use disorders. However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary. (2)
- For clients who are blind or visually impaired, keep pathways clear and raise low-hanging signs or lights. Use large letter signs and add Braille labels to all signs and elevator buttons. Make oral announcements; do not rely on a bulletin board. (2)
- People who are blind or visually impaired will require assistance to orient themselves to a new environment. The treatment provider should give clients who are blind a complete orientation to the facility the first time they visit; the client can be guided by holding her arm just above the elbow and walking with her through the rooms, explaining where the doors, furniture, and other features are. (2)

TOP

Screening for Disabilities

- Because many disabilities are not obvious, it is important to screen for them in every person, not just those with obvious functional limitations. Ask all clients entering treatment whether they require any accommodations in order to participate. (2)
- It is the level of abilities and of the functioning of the individual--not the simple determination of whether an impairment exists--that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services) treatment providers should refer the client to a disabilities services professional. (2)
- Although it is a good idea to get background information from as many sources as possible, interview the person alone, if possible. Having others present often distorts the quality of the interview. (2)
- Intake interviews should begin with an open and friendly question, not one that is focused on the person's disability. (2)
- An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should ascertain the pathology

of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. (2)

- If there are forms to be completed as part of intake processing, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Individuals who are both deaf and blind will need a tactile interpreter to translate for them during the admissions process and afterward. (2)
- Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed assessment information. Written English forms and questionnaires should be interpreted into sign language for these clients. (2)
- When screening people with cognitive disabilities, be as specific as possible--rather than asking if they "use alcohol," ask if they like to drink beer, wine, wine coolers, etc. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed. (2)

TOP

Treatment Planning

- For treatment to succeed, all clients must understand the particular strengths that they can bring to the recovery process. A strengths-based approach to treatment is especially important for people with disabilities, who, because they have so frequently been viewed in terms of what they cannot or should not attempt, may have learned to define themselves in terms of their limitations and inabilities. (2)
- It is key to the treatment planning process for the treatment provider to learn where a person with a disability is on the spectrum of understanding and accepting his disability. (2)
- No treatment plan should be static, and treatment providers must continually evaluate and revise the treatment plan with assistance from clients with disabilities. Treatment plans should be flexible enough to take into account changes in a person's condition or new knowledge gained during treatment. Clients with traumatic brain injury, for example, often show a dramatic recovery curve over the year to two years following their accidents. (2)
- An individual with a disability may also need to explore several methods for learning something or fulfilling a goal before an accomplishable approach to the situation can be identified and implemented. (2)
- The treatment plan should document all alterations to the usual treatment procedures that are being made. If an approach does not work, the outcome should still be carefully documented to prevent duplication of effort by other programs in the future. Similarly, details of what is successful for a person should be documented, particularly for persons with cognitive disabilities who may not be able to tell future caregivers which treatments have been effective and why. (2) Documentation of all efforts at accommodation is needed to verify ADA compliance. (1)
- It is helpful to identify early on any needed exceptions to the routines of the treatment program for a person with a disability and to explain to other clients that the accommodations for a person with a disability simply give her the help she needs to meet shared goals. If the client does not object, the exceptions and the rationale for these exceptions should be discussed openly in group meetings. (2)

- Behavioral contracts with people with coexisting disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be specifically tailored to what the individual is realistically capable of achieving. (2)
- People who are deaf or hard of hearing (and probably those with other disabilities as well) generally know less about addiction and recovery when they enter treatment than nondeaf (or nondisabled) people, and therefore they will often require lengthier treatment. Treatment providers should be prepared to allow for longer treatment times for clients with disabilities. (1)
- It is essential that all clients participate in planning leisure activities, and programs with rigid approaches that exclude clients from such participation should consider changing their policies. (2)
- If a person with a disability has limited transportation options, conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. (2)
- For people with coexisting disabilities, failure to achieve treatment goals may indicate that the treatment plan lacks the discrete steps necessary to meet those goals. In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. (2)
- Early in treatment, a medical professional should conduct an assessment of all the client's medications--both prescribed and over-the-counter, including herbs and vitamins. In addition, the Panel recommends that a single medical professional try to monitor the client's medication regimen. Under no circumstances, however, should other treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. (2)
- Lack of employment may be a factor in substance abuse; conversely, addressing and overcoming barriers to employment, with the aid of collaborative partners, may greatly enhance the prospect for recovery and should be addressed as a component of treatment planning. (2)

TOP

Counseling

- Counseling session times should be flexible, so that sessions can be shortened, lengthened, or more frequent, depending upon the individual treatment plan. (2)
- For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat, in her own words, what has been said. Discussions should be kept concrete. People with mental retardation or traumatic brain injury may not understand abstract concepts; they should be asked to provide specific examples of a general principle. (2)
- The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group sessions run more smoothly for all. The counselor and the person with a disability together can design the cues but should keep them simple, such as touching the person's leg and saying a code word (e.g., "interrupting"). (2)

- Clients with cognitive disabilities will often benefit from techniques such as expressive therapy or role-playing. (2)
- Assignments that require the use of alternative media in place of writing may work best with clients who have cognitive disabilities as well as those who are deaf. (2) Clients who are blind will need assignments translated into their preferred method of communication (e.g., Braille, audiotape), but no matter what method is used they will require more time to complete reading assignments. (1)
- Regardless of the model of communication used by the person who is deaf or hard of hearing, the visual aspect of communication will be important. Therefore, it is important to look directly at the person when communicating. This will allow him to try to read the lips of the counselor and to see her facial expression. (2)
- Interpreters should usually be provided for people who are deaf or hard of hearing. (1) The interpreter should be a neutral third party hired specifically to interpret for the counselor and the person who is deaf; a family member or friend of the client should not be used as an interpreter. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization. (2)
- If a person who is deaf is using an interpreter, group members will need to take turns during discussions. When addressing a person who is deaf the counselor or group members should speak directly to the person as if the interpreter is not present. (2)
- When working with an individual with a physical disability, make certain that table surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks. (2)
- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair and push the person without permission. (2)
- For individuals with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare. (2)
- In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. Asking before rendering any service is a basic principle. (2)

TOP

Linkages

- Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not already being provided by the substance use disorder treatment program. Treatment plans for people with coexisting disabilities should address problems such as unemployment, a lack of recreational

options, social isolation, and physical abuse because they are more likely than the general population to experience these situations. (2)

- Service linkages are essential to provide effective substance use disorder treatment for people with coexisting disabilities. (2)
- Treatment providers need to be able to identify what ancillary services are available for their clients, and be able to access those services and funding sources. (2)
- Since a client having a substance use disorder and a disability may also be in a physical rehabilitation or other disability program, treatment professionals should be aware of the various approaches used by these other programs, and know how to collaborate with them. The Panel recommends cross-training between vocational rehabilitation or other disability service providers and substance use disorder treatment providers to help treatment professionals understand the impacts of both disability and substance use disorders. (2)
- In developing partnerships with referring agencies, the treatment program should ensure, through interagency agreements, that mechanisms are in place for exchanging client information. (2)
- It is not unusual for services to be duplicated or ineffective when a case manager is not utilized, and so a substance use disorder treatment provider may need to either case manage these services or find another organization or person to do so. A case manager can be a strong advocate for a person with a disability and help her locate appropriate and accessible services. (2)
- A substance abuse counselor may not have the time or the expertise to work on all the issues that arise because of a client's disability. If that is the case, a referral to a peer counselor at a Center for Independent Living, whose job it is to help disabled individuals come to terms with the limits of their disabilities, may be in order. The two counselors can work together as a team. (2)
- The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. (2)

TOP

Organizational Commitment

- Providers must be prepared to act as advocates for their clients when services and supports that are normally readily available and effective prove inaccessible for the client. (2)
- When treatment teams make the effort to accommodate individuals with coexisting disabilities, the quality of care improves for all clients. All clients can get more out of treatment that is individualized and that takes their specific functional capacities and limitations into account. (2)
- To ensure full organizational support for treating people with coexisting disabilities, the Consensus Panel recommends that a treatment program develop a policy statement that articulates the program's willingness to accommodate any individual with a disability who chooses to attend the program. (2)
- When a program makes a commitment to serving people with coexisting disabilities, board membership of people with disabilities may be implemented immediately or considered as a goal to be reached as the program begins to serve a greater number of

people from these groups. A program should try to obtain regular input from the community it seeks to serve; creating a permanent task force or an advisory committee is an ideal way to address this need. (2)

- The organization must make a commitment to continually reexamine the program's effectiveness for people with coexisting disabilities. Such inquiry can take place both formally, using quality assurance methods and consumer satisfaction surveys, and informally, through opportunities for individual and group feedback with program staff. (2)
- It is not enough for a program simply to be ready to serve people with coexisting disabilities. Rather, the program should be proactive in making the disability community aware of its services to ensure that disability organizations will support referrals to the program. (2)
- Another sign of organizational commitment is to hire people with disabilities to work in the treatment program. Hiring people with disabilities also benefits other staff members, who can learn from these coworkers. (2)
- The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of whatever other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform a substance use disorder assessment and refer the client for treatment elsewhere. (2)

TOP

Improving Treatment for All Clients

Treatment that is planned and provided on a case-by-case basis will benefit everyone, not just those clients with coexisting disabilities. All people have different functional capacities and limitations, and an evaluation of these, as described and encouraged in this TIP, will help providers focus on individual needs. This TIP explores the treatment needs of people with particular types of disabilities, but the processes of assessment and evaluation it suggests can help all clients gain greater benefit from treatment.

There is a growing belief in the substance use disorder treatment field that treatment is more successful if it can respond to all the needs of an individual, not just the need to stay away from alcohol and drugs. If treatment is to succeed for a client with a coexisting disability, a wide range of services may be required. For this reason, this TIP strongly encourages the use of case management services and service linkages. The TIP also aims to educate people in both the disability services and substance use disorder treatment fields concerning the problems faced by people who have both a substance use disorder and a coexisting disability. A better understanding of the needs of these clients and the services available to them can be gained through reading this TIP. TOP